Workforce Development and Training:

Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS)

September 9, 2005
Updated June 2008

Introduction

- This report was prepared as part of a group process involving the Co-Occurring Center for Excellence (COCE) and the Co-Occurring State Incentive Grants (COSIGs) from 2003-2005.
- The content of this report is intended as an introduction to the topic of workforce development, rather than an exhaustive review.
- This report is adapted from TIP 42 and presentations to the COSIG Workforce Development & Training Workgroup by Dr. Donna McNelis, Ms. Pat Stilen, LCSW, CADAC, and Dr. Joan Zweben, COCE Senior Fellow, and was updated in June 2008 for posting to the COCE Web.
- The SAMHSA Federal Project Officer for COCE is Charlene E. Le Fauve, Ph.D. (CSAT).

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Workforce Development and Staff Support

Outline

- **Background**
- **Attitudes and Values**
- **Clinicians' Competencies**
- **Avoiding Burnout and Reducing Staff Turnover**
- **Continuing Professional Development**
- **Solution to Workforce Dilemmas**
- **Conclusion**

Background

Who is the Work Force?

- **All those who provide treatment, care, and support to people with COD**
- **Caregivers in other systems:**
  - **Criminal justice system**
  - **Primary care settings**
  - **Social services**
  - **Schools**
  - **Natural caregivers: mental health consumers, people in recovery and their families**

Zweben, J. (2005)

Substance Abuse Treatment Workforce Survey Report (Missouri)*

- **Represents 63 treatment agencies, many include MH/SA services**
- **Response rates**
  - **Staff (48%)**
  - **Directors (55%)**
- **Methodology**
  - **Utilized a modified workforce survey developed by RMC Research Corp for the NW Frontier ATTC conducted in 2004**
  - **Agencies randomly selected from SAMHSA's treatment facility locator system**
  - **Forty percent of Missouri's agencies selected (N=76)**

www.mattc.org

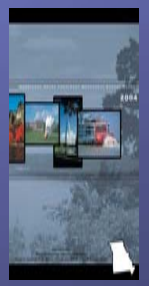
Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

COCE
SAMHSA's Co-Occurring Center for Excellence

* Need for additional information on MH and COD Workforce

Survey Results: Skills and Training Needs

- **Majority not familiar with CSAT's Addiction Counselor Competencies**
- **Least confident about their work with co-occurring mental health disorders**
- **Training needs identified most frequently**
  - **Co-occurring disorders**
  - **Psychopharmacology**
  - **Motivational interviewing**



Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

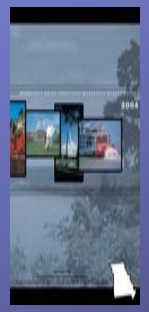
Survey Results: Supports/Stressors for Workforce

Job Retention

- Salaries, benefits, recognition, training

Agency Support Systems

- Clinician supervision, mentoring, training



Job Satisfaction

- Direct service, conditions of employment

Barriers to Recruitment

- Low pay, stigma associated with addiction, competition with other fields

Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

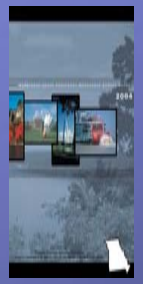
Survey Results: Supports/Stressors for Directors

Consultation needed

- Teach staff client assessment, using assessments to document program effectiveness, raise quality of counseling

Source of pressure for change

- Funding entities



Adequacy of work resources

- Need quality staff

Leadership reported readiness to change

- Directors self-report openness to change and perceived having adequate influence for change efforts in agency

Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

Survey Results: **Workforce Demographics**

- **Addiction workforce more educated than anticipated (47.9% staff; 70.8% directors held graduate degrees)**
- **Education levels strongly associated with salary**
- **Fewer workers receive retirement options**
- **If primary role was “individual counseling,” clinician tended to be more educated**

Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

Survey Results: Provision of Services for Co-Occurring Disorders

- Regardless of educational level, staff equally likely to be involved in treatment
- Assessment and diagnosis left to those with higher levels of education
- Graduate-degreed staff more than twice as likely as those with bachelor's degrees to be involved in screening for co-occurring disorders
- In contrast, all staff are equally involved in screening for substance abuse only
- Graduate-degreed staff reported significantly higher self-efficacy for work in this area

Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

Other State Workforce Development Information

New York Whitepaper on Addictions Workforce
(Institute for Professional Development in the Addictions, 2002)

- ***Prepared to inform and advise policy makers, educators, representatives of government, and foundations about the workforce crisis and to provide recommendations***

New York Whitepaper on Addictions Workforce 2002

Identification of Workforce Crisis:

- Increase in professionalism in the field including increase of addiction specialties across disciplines, but fewer people are choosing the field and there is a rise in the numbers of people leaving
- Field is in transition from experientially trained workforce to one that emphasizes graduate training

IPDA, 2002

New York Whitepaper on Addictions Workforce 2002 (continued)

- **Areas of Workforce Challenges**
  - **Attitudinal perspectives**
  - **Interdisciplinary approaches**
  - **Education and training**
  - **Recruitment and retention**
  - **Funding and advocacy**

IPDA, 2002

CSAT 2003 Survey of NAADAC Early Career Substance Abuse Counselors

- **Sample included 359 NAADAC members**
- **Response rate of 200 (56%)**
- **Methodology**
  - Computer Assisted Telephone Interviewing (CATI) system from September 24, 2002 to November 27, 2002.
  - Final corrected study sample included 140 members with 4 or fewer years in the substance abuse field

CSAT 2003 Survey of NAADAC Early Career Substance Abuse Counselors

Survey Findings: Characteristics of Counselors

- **70% female, 78% white, 42 y/o mean**
- **40 % master's degrees**
- **Drawn to field by personal factors**
- **50% see opportunity for career advancement**

CSAT, 2003

2005 NFATTC Substance Abuse Treatment Workforce Survey in Idaho

- **Sample included 56 agency directors (who were asked to send surveys to each treatment facility they managed**
- **Response rate of 33 agency directors (59%) and 92 clinicians**
- **Methodology**
  - Utilized the 2005 NFATTC Workforce Survey Instrument
  - Surveys were mailed to the full census of administrators in Idaho (1 for each agency director and 5 for clinicians at treatment facilities)
  - Data collection occurred between October 2005 and March 2006

2005 NFATTC Substance Abuse Treatment Workforce Survey in Idaho

2005 ATTC Survey Findings

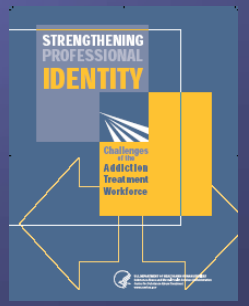
Substance Abuse Clinician Characteristics:

- 63% female, 93% white, 42 years old (avg age)
- 74% BA, 34% graduate degree
- 42% have specialized certificate; 28% licensed
- 90% participated in trainings in the past 2 years
- 70% of clinicians carry a caseload; average case load is 22 clients
- 93% earn less than $45,000/yr
- Turnover rate 23%

NFATTC and RMC Research Corp, 2006

Trends Impacting Addiction Treatment Workforce

- **Insufficient workforce capacity to meet demand**
- **Changing profile of those needing service**
- **Shift to increased public financing of treatment**
- **Challenges related to adoption of best practices**



Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce (2006)

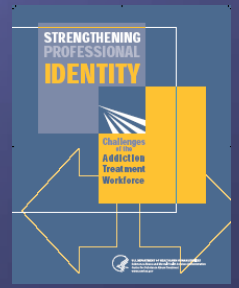
Trends Impacting Addiction Treatment Workforce *Continued*

- **Increased utilization of medications in treatment**
- **Movement toward recovery model of care**
- **Provision of treatment and related services in non-traditional settings**
- **Use of performance outcome measures**
- **Discrimination (stigma) associated with addiction**

Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce (2005)

Emerging Themes Related to Workforce

- **Infrastructure development w/ emphasis on revising core competency standards**
- **Clinical supervision**
- **Leadership/mentor development**
- **Expansion of health care recruitment strategies**
- **Academic accreditation for multidisciplinary workforce**



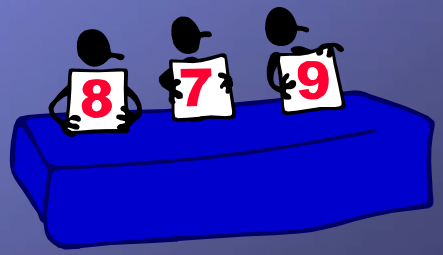
Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce (2005)

Workforce Research

Most treatment outcome studies are designed to evaluate treatments - not members of the workforce

- **Focus on comparisons between treatment modalities**
- **Less focus on counselor differences**

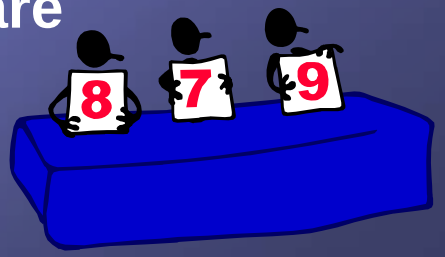
We know counselor effectiveness impacts client retention in treatment!



Clinician's Impact on Substance Abuse Treatment, Najavits, Crits-Christoph, and Dierberger (2000)

Workforce Research *Continued*

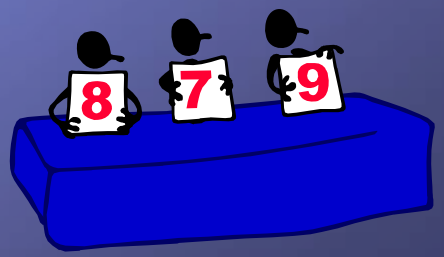
- **Clinical outcomes are MORE influenced by**
- **Counselor emotional responses (counter transference)**
  - **Burnout, job dissatisfaction, navigating splits between MH/SA systems**
- **Counselor interpersonal functioning and ability to foster therapeutic alliance (mixed findings)**
- **Professional practice issues**
  - **Systems issues in coordinating SA/MH care**



Clinician's Impact on Substance Abuse Treatment, Najavits, Crits-Christoph, and Dierberger (2000)

Research findings are inconclusive on these counselor characteristics

- **Personality features**
- **Beliefs about SA/MH treatment**
- **Views on 12-step groups**
- **Confidence and/or self-efficacy**
- **Clinician recovery status**



Clinician's Impact on Substance Abuse Treatment, Najavits, Crits-Christoph, and Dierberger (2000)

Attitudes & Values

Attitudes and Values

- **Attitudes and values guide the way providers meet client needs and affect the overall treatment climate.**
- **They not only determine how the client is viewed by the provider (thereby generating assumptions that could either facilitate or deter achievement of the highest standard of care), but also profoundly influence how the client feels as he or she experiences a program.**
- **Attitudes and values are particularly important in working with clients with COD since the counselor is confronted with two disorders that require complex interventions.**

CSAT (2005)

Essential Attitudes and Values for Clinicians Who Work With Clients Who Have COD

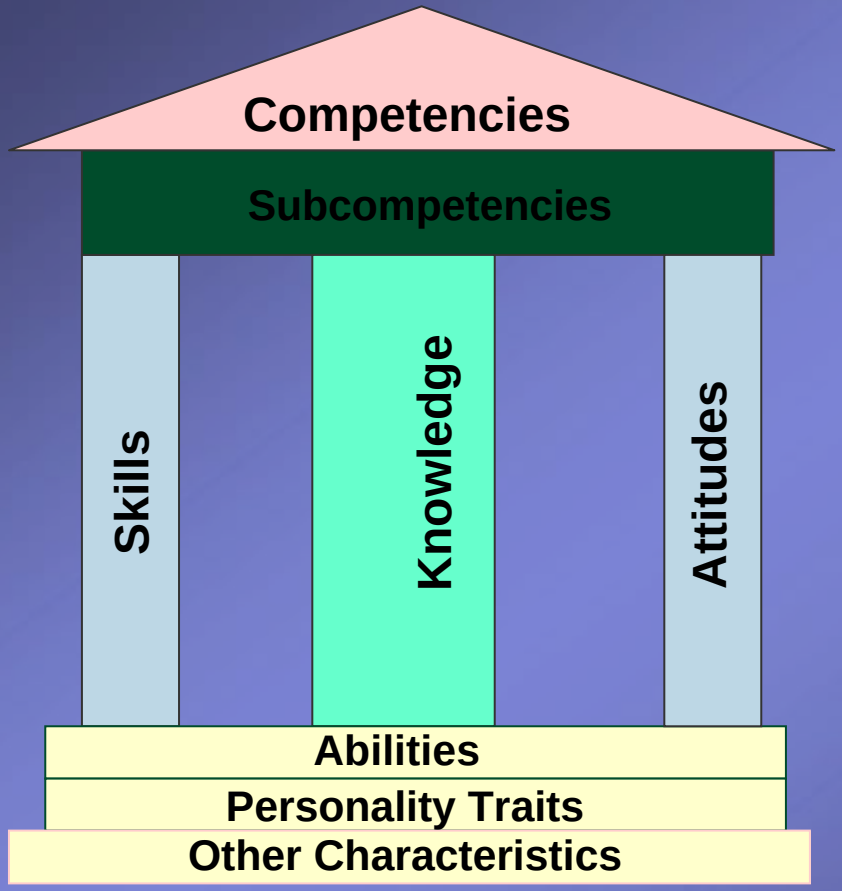
1. Desire and willingness to work with people who have COD
2. Appreciation of the complexity of COD
3. Openness to new information
4. Awareness of personal reactions and feelings
5. Recognition of the limitations of one's own personal knowledge and expertise
6. Recognition of the value of client input into treatment goals and receptivity to client feedback
7 . Patience, perseverance, and therapeutic optimism
8. Ability to employ diverse theories, concepts, models, and methods
9. Flexibility of approach
10. Cultural competence
11. Belief that all individuals have strengths and are capable of growth and development (added by consensus panel)
12. Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

CSAT (2005)

Competencies

Clinician Competence Models

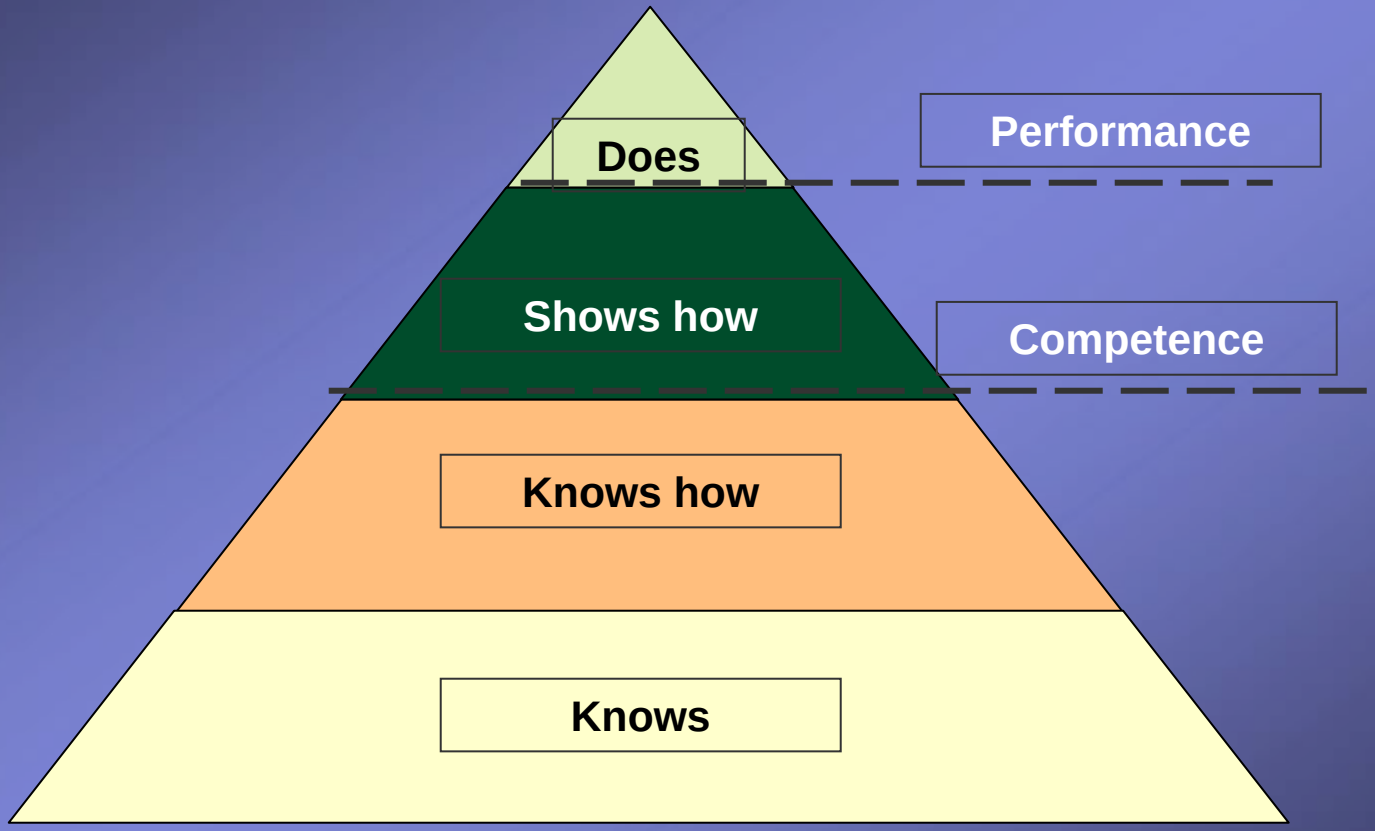
Competence Architecture Model (Roe, 2002)



"The model proposed by Roe can be visualized as a Greek temple (see Figure 1). He depicts expected competencies capping a building that has foundation layers of abilities, personality traits, and other personal attributes, all potentially measurable by assessment methods. Pillars of acquired learning are the traditional KSAs (knowledge, skills, and attitudes) where depth and breadth of learning are assessed. Practical learning supports the roof during supervised training. The knowing how and when that integrates the KSAs with the foundation layers become subcompetencies. Subspecialties combine KSAs with other abilities and personal attributes, all of which work together when performing a specific and demonstrable part of the clinical care." **(Bashook, 2005)**

Miller's Triangle of Competence Assessment

(Miller, 1990)



Best Practices for Assessing Competence and Performance of the Behavioral Health Workforce, Bashook (2005)

Core Competencies for COD

Framework

- **Develop minimum core competencies for each clinician, in accordance with job role, level of training or license to provide properly matched integrated service to individuals in their system**
- **Competencies defined by TIP #42: Basic, Intermediate, and Advanced**

CSAT (2005)

See also Minkoff & Ajilore (1998)

Examples of Basic Competencies Needed for Treatment of Persons With COD

Perform a basic screening to determine whether COD might exist and be able to refer the client for a formal diagnostic assessment by someone trained to do this.
Form a preliminary impression of the nature of the disorder a client may have, which can be verified by someone formally trained and licensed in mental health diagnosis.
Conduct a preliminary screening of whether a client poses an immediate danger to self or others and coordinate any subsequent assessment with appropriate staff and/or consultants.
Be able to engage the client in such a way as to enhance and facilitate future interaction.
De-escalate the emotional state of a client who is agitated, anxious, angry, or in another vulnerable emotional state.
Manage a crisis involving a client with COD, including a threat of suicide or harm to others. This may involve seeking out assistance by others trained to handle certain aspects of such crises; for example, processing commitment papers and related matters.
Refer a client to the appropriate mental health or substance abuse treatment facility and follow up to ensure the client receives needed care.
Coordinate care with a mental health counselor serving the same client to ensure that the interaction of the client's disorders is well understood and that treatment plans are coordinated.

CSAT (2005)

Intermediate Competencies

- **Intermediate competencies encompass skills in engaging substance abuse treatment clients with COD, screening, obtaining and using mental health assessment data, treatment planning, discharge planning, mental health system linkage, supporting medication, running basic mental disorder education groups, and implementing routine and emergent mental health referral procedures.**
- **In a mental health unit, mental health providers would exhibit similar competencies related to substance use disorders.**
- **The consensus panel recommends the intermediate level competencies, which were developed jointly by the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services.**

CSAT (2005)

Six Areas of Intermediate-Level Competencies Needed for the Treatment of Persons With COD

Competency I: **Integrated Diagnosis of Substance Abuse and Mental Disorders. Differential diagnosis, terminology (definitions), pharmacology, laboratory tests and physical examination, withdrawal symptoms, cultural factors, effects of trauma on symptoms, staff self-awareness.**

Competency II: **Integrated Assessment of Treatment Needs. Severity assessment, lethality/risk, assessment of motivation/readiness for treatment, appropriateness/treatment selection.**

Competency III: **Integrated Treatment Planning. Goal-setting/problem solving, treatment planning, documentation, confidentiality,* legal/reporting issues, documenting issues for managed care providers.**

Competency IV: **Engagement and Education. Staff self-awareness, engagement, motivating, educating.**

Competency V: **Early Integrated Treatment Methods. Emergency/crisis intervention, knowledge and access to treatment services, when and how to refer or communicate.**

Competency VI: **Longer Term Integrated Treatment Methods. Group treatment, relapse prevention, case management, pharmacotherapy, alternatives/risk education, ethics, confidentiality,* mental health, reporting requirements, family interventions.**

***Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).**

CSAT (2005)

Advanced Competencies

- **At the advanced level, the practitioner goes beyond an awareness of the addiction and mental health fields as individual disciplines to a more sophisticated appreciation for how co-occurring disorders interact in an individual.**
- **This enhanced awareness leads to an improved ability to provide appropriate integrated treatment. Slides 37-38 provide examples of advanced competencies.**

CSAT (2005)

Examples of Advanced Competencies in the Treatment of Clients With COD

- **Use the current edition of criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Revised edition* (American Psychiatric Association 2007) to assess substance-related disorders and Axis I and Axis II mental disorders.**
- **Comprehend the effects of level of functioning and degree of disability related to both substance-related and mental disorders, separately and combined.**
- **Recognize the classes of psychotropic medications, their actions, medical risks, side effects, and possible interactions with other substances.**
- **Use integrated models of assessment, intervention, and recovery for persons having both substance-related and mental disorders, as opposed to parallel treatment efforts that resist integration.**
- **Apply knowledge that relapse is not considered a client failure but an opportunity for additional learning for all. Treat relapses seriously and explore ways of improving treatment to decrease relapse frequency and duration.**

CSAT (2005) and from Minkoff, K. (1999.)

Examples of Advanced Competencies in the Treatment of Clients With COD *(Continued)*

- **Display patience, persistence, and optimism.**
- **Collaboratively develop and implement an integrated treatment plan based on thorough assessment that addresses both/all disorders and establishes sequenced goals based on urgent needs, considering the stage of recovery and level of engagement.**
- **Involve the person, family members, and other supports and service providers (including peer supports and those in the natural support system) in establishing, monitoring, and refining the current treatment plan.**
- **Support quality improvement efforts, including, but not limited to: consumer and family satisfaction surveys, accurate reporting and use of outcome data, participation in the selection and use of quality monitoring instruments, and attention to the need for all staff to behave respectfully and collaboratively at all times.**

CSAT (2005) and Minkoff, K. (1999).

Clinicians' Competencies

- **Clinicians' competencies are the specific and measurable skills that counselors must possess.**
- **Several States, university programs, and expert committees have defined the key competencies for working with clients with COD.**
- **Typically, these competencies are developed by training mental health and substance abuse treatment counselors together, often using a case-based approach that allows trainees to experience the insights each field affords the other.**

CSAT (2005)

COD Clinical Competencies

Assessment

- **Severity assessment**
- **Lethality/risk**
- **Assessment of motivation/readiness for treatment**
- **Appropriateness/treatment selection**
- **Family interventions**

McNelis, D. (2005)

Diagnosis

- Differential diagnoses
- Terminology (definitions)
- Pharmacology
- Laboratory tests and physical examination
- Withdrawal symptoms
- Cultural factors
- Effects of trauma on symptoms
- Staff self-awareness

McNelis, D. (2005)

Integrated Treatment Planning

- Goal setting/problem solving
- Treatment Planning
- Documentation
  - Confidentiality
  - Legal/reporting issues
  - Documenting re: managed care issues

McNelis, D. (2005)

Engagement and Education

- Staff self-awareness regarding recovery
- Engagement
- Motivating
- Educating

McNelis, D. (2005)

Early Integrated Treatment Methods

- Emergency/crisis intervention
- Knowledge and access to treatment services
- When and how to refer
- Integrating/communicating

McNelis, D. (2005)

Longer Term Integrated Treatment Methods

- Group treatment
- Relapse prevention
- Case Management
- Pharmacotherapy
- Alternatives/harm reduction

McNelis, D. (2005)

Measuring Addiction Competencies

- **Technical Assistance Publication (TAP) 21 (CSAT, 2006) gives detailed description of the competencies**
- **Work in progress on benchmarks or descriptions of behavior to document progress in mastery of competencies**
- **Rubrics describe effective behaviors for the developing, proficient, and exemplary counselor**
- **Will need to be adapted for COD**

Zweben, J. (2005)

Avoiding Burnout & Reducing Staff Turnover

Avoiding Burnout

- **Work within a team structure rather than in isolation.**
- **Build in opportunities to discuss feelings and issues with other staff who handle similar cases.**
- **Develop and use a healthy support network.**
- **Maintain the caseload at a manageable size.**
- **Incorporate time to rest and relax.**
- **Separate personal and professional time.**

CSAT (2005)

Reducing Turnover

To decrease staff turnover, whenever possible, programs should

- **Hire staff members who have familiarity with both substance abuse and mental disorders and have a positive regard for clients with either disorder**
- **Hire staff members who are critically minded and can think independently, but who are also willing to ask questions and listen, remain open to new ideas, maintain flexibility, work cooperatively, and engage in creative problem-solving**
- **Provide staff with a framework of realistic expectations for the progress of clients with COD**
- **Provide opportunities for consultation among staff members who share the same client (including medication providers)**

CSAT (2005)

Reducing Turnover *(Continued)*

- **Ensure that supervisory staff members are supportive and knowledgeable about issues specific to clients with COD**
- **Provide and support opportunities for further education and training**
- **Provide structured opportunities for staff feedback in the areas of program design and implementation**
- **Promote sophistication about, and advocacy for, COD issues among administrative staff, including those in decision-making positions (e.g., the director and clinical director) and others (e.g., financial officers, billing personnel, and State reporting monitors)**
- **Provide a desirable work environment through adequate compensation, salary incentives for COD expertise, opportunities for training and for career advancement, involvement in quality improvement or clinical research activities, and efforts to adjust workloads**

CSAT (2005)

Continuing Professional Development

Continuing Professional Development

Main Methods

- **Discipline-Specific Education**
- **Continuing Education and Training**
- **Cross-Training**
- **Program Orientation and Ongoing Supervision**
- **National Training Resources**

CSAT (2005)

Substance Abuse Treatment Workforce Survey Report (Missouri)*

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www.mattc.org

Mid-America Addiction Technology Transfer Center, Murdock & Wendler (2005)

COCE
SAMHSA's Co-Occurring Center for Excellence

* Need for additional information on MH and COD Workforce

Missouri Survey Findings: What Training Is Most Useful?

Comments on usefulness of all training modules fell into two categories:

Content

- Brain function/chemistry
- Medication
- SA/MH "connection"
- Checklists
- Stages of Change Model
- Screening/assessment tools
- Mental health disorders
- Family dynamics and treatment

Group Process

- Sharing of knowledge
- How to integrate services
- Networking
- Content discussions
- Group interactions
- Collaboration
- Diagnosing case studies
- How to apply to workforce

Stilen, P. (2005)

Missouri Survey Findings: Post-Training Professional Goals

- **Enhance Client Treatment Planning**
  - Use MH and/or SA screening tools in my practice
  - Develop individualized treatment plans from biopsychosocial perspective
  - Become more familiar with a particular treatment model
- **Promote Multidisciplinary Collaboration**
  - Use multidisciplinary staff in consultation and/or staffing
  - Develop linkages with other programs

Stilen, P. (2005)

Rethinking Focus on Workforce

- **It is natural to look at MH/SA practitioner when developing competencies.**

but

The Fundamentals of Workforce Competency: Implications for Behavioral Health, Hoge, Tondora, & Marrelli (May/July 2005)

What About Organizational Context?

1. Individual competencies
2. Nature of information available
   - Clarity of performance goals
   - Standards, policies, work processes, feedback
3. Environment
   - Organizational culture and values
   - Physical characteristics of work setting
4. Tools
   - Job aids, computer systems, equipment, supplies
5. Motivational enhancements
   - Consequences for performer, appraisal/promotional system, compensation, monetary/non-monetary incentives, peer pressure

The Fundamentals of Workforce Competency: Implications for Behavioral Health, Hoge, Tondora, & Marrelli (May/July 2005)

Mechanisms for Improving the Workforce

Levers for Change

- **Financing**
- **Infrastructure development**
- **Legislation**
- **Regulation**
- **Accreditation (education programs, service delivery organizations)**
- **Certification and licensure**
- **Performance based contracting**

Zweben, J. (2005)

Table of Evidence- & Consensus-Based Practices for Co-Occurring Disorders

Consensus-Based		Evidence-Based		
Guiding Principles	Essential Programming	Evidence-Based Practices in Substance Abuse Treatment*	Evidence-Based Practices in Mental Health**	Evidence-Based Practices for Persons with COD*
Employ a Recovery Perspective	Screening, Assessment, and Referral	Motivational Enhancement	Medical Management Approaches in Psychiatry	Assertive Community Treatment
Adopt a Multi-Problem Viewpoint	Psychiatric and Mental Health Consultation	Contingency Management Techniques	Family Psycho-education	Modified Therapeutic Community
Develop a Phased Approach to Treatment	Intensive Case Management	Cognitive–Behavioral Therapeutic Techniques	Supported Employment	Integrated Dual Disorder Treatment
Address Specific Real-Life Problems Early in Treatment	Prescribing Onsite Psychiatrist	Relapse Prevention	Illness Management and Recovery Skills	
Plan for the Client's Cognitive and Functional Impairments	Medication and Medication Monitoring	Repetition and Skills-Building	Assertive Community Treatment	
Use Support Systems to Maintain and Extend Treatment Effectiveness	Psychoeducational Classes	Client Participation in Mutual Self-Help Groups	Integrated Dual Disorder Treatment (Substance Use and Mental Illness)	
	Double Recovery Groups (Onsite)			
	Mutual Self-Help Groups (Offsite)			

•CSAT (2005)
•**CMHS (2002)

Embracing all Technological & Knowledge Advances

- **Undergraduate and graduate education**
- **Continuous education**
- **Judicious internet and listserv information**
  - **Dualdx@treatment.org**
  - **www.ireta.org/attc**
  - **Systems change technology**
  - **Change agents at all levels**
  - **CQI approaches**

McNelis, D. (2005)

- SAMHSA Office of Workforce Development
- Psychopharmacology
- Application of Cultural Competence
- Partnering with consumers and families
- Clinical/research partnerships

McNelis, D. (2005)

Clinical Training

- **Need for a comprehensive approach with appropriate sequence of courses.**
- **Incentives:**
  - **Certificate of Achievement**
  - **CEU's**
  - **Recognizing proficiency in evaluations and promotions**
- **Proceed in tandem with relevant system changes.**

Zweben, J. (2005)

Clinical Supervision

- Regular caseload meeting with a supervisor
- Case review
- Team review

Cultural Competence

- **Requires that organizations:**
  - **Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally**
  - **Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve**
  - **Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders and communities.**

See Web site (listed below) for details on Culturally Competent Guiding Values and Principles

Source: http://gucchd.georgetown.edu/nccc/index.html

Expanding the Workforce

- **Status and salary are low; average counselor salary is $34,000**
- **Need executive management curriculum to train leaders and managers**
- **Recruit from diverse ethnic and cultural groups**
- **Employ some licensed professionals to offer practicum, intern, and postdoctoral experiences**

Zweben, J. (2005)

Retaining Members of the Workforce

- **Factors influencing turnover**
  - **Job autonomy**
  - **Good communication within the program**
  - **Recognition and rewards for performance**
  - **Augment existing sources of satisfaction**
- **Onsite training builds skills and enhances morale**
- **Streamline paperwork**

Zweben, J. (2005)

ATTC Leadership Institute

- **Goal: Cultivate new leaders through development of competencies in mid level managers (no@nattc.org).**
- **Traditional training seminars and field experiences over 6 months.**
- **Mentor/protégé pairs focus on Individual Leadership Development Plan.**
- **Leadership project presented at graduation.**

Zweben, J. (2005)

Conclusions

- COCE strongly encourages counselors to acquire the competencies needed to work effectively with clients who have COD.
- The difficulty of juggling a high and demanding workload and the desire for continued professional development should be recognized and accommodated.
- To the extent possible, education and training efforts should be customized—in terms of content, schedule, and location—to meet the needs of the counselors in the field. That is, bring the training to the counselor.
- Agency and program administrators, including both line-level and clinical supervisors, are urged to demonstrate support and encouragement for the continuing education and training of the workforce, as well as develop COD competencies themselves.
- Rewards can include both salary and advancement tied to the counselor's efforts to increase his or her effectiveness in serving clients with COD, as demonstrated by job performance.

What Next?

- Synthesize disparate studies of workforce
- Describe distinctive issues for those working with COD
- Determine effective methods for training, improvement and retention
- Develop effective ways of determining and promoting competency
- Raise standards without creating barriers

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